

Welcome

*The benefits of a happy, healthy smile are immeasurable!
 Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
 The better we communicate, the better we can care for you.*

1. ABOUT YOU

Name _____
 Preferred Name _____ Male Female
 Single Married Divorced Widowed Separated
 Birthdate _____ Age _____ SS# _____
 Address _____
 City _____ State _____ Zip _____
 Email _____
 Home # _____ Work # _____
 Mobile # _____ Fax # _____
 Whom may we thank for referring you? _____
 Other friends or family members seen here _____

 Employer _____ Employer ph # _____
 Employer Address _____
 City _____ State _____ Zip _____
 How long were you employed there? _____

4. INSURANCE

Provider Name _____
 Provider Address _____
 City _____ State _____ Zip _____
 Group # _____
 Insured's Name _____ Relation _____
 Insured's Birthdate _____ Insured's ID# _____
 Insured's Employer _____ Insured's Ph# _____

SECONDARY INSURANCE

Provider Name _____
 Provider Address _____
 City _____ State _____ Zip _____
 Group # _____
 Insured's Name _____ Relation _____
 Insured's Birthdate _____ Insured's ID# _____
 Insured's Employer _____ Insured's Ph# _____

2. ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
 Home # _____ Work # _____
 Mobile # _____ Birthdate ____/____/____
 Email _____
 Billing Address _____
 City _____ State _____ Zip _____

3. SPOUSE/SIGNIFICANT OTHER

Name _____ Relationship _____
 Home # _____ Work # _____
 Mobile # _____ Birthdate ____/____/____

5 A. MEDICAL HISTORY

Do you have a personal physician?
 Physician's Name _____
 Phone # _____ Last visit date _____
 Are you currently under the care of a physician?
 Please explain _____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____
 Home # _____ Work # _____

*Thank you for filling out this form completely.
 It will allow us to serve you more effectively.
 If you have a question at any time, please ask us.
 We are more than happy to help!*

5 B. MEDICAL HISTORY

Your current physical condition Good Fair Poor
 Do you smoke or used tobacco in any form? Yes No
 Are you taking any prescription / Over-the-counter or herbal
 supplemental drugs? Yes No
 Please list each one _____

Have you ever taken Phen-fen? (Also known as Redux or
 Pondimin) Yes No
 If yes, when? _____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No
 Are you pregnant? Yes No Week # _____
 Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes No	Abnormal Bleeding	Yes No	Herpes/ Fever Blisters
Yes No	Alcohol / Drug abuse	Yes No	High blood pressure
Yes No	Anemia	Yes No	HIV+ / AIDS
Yes No	Arthritis	Yes No	Hospitalized for any reason
Yes No	Artificial bones, joints, or valves	Yes No	Kidney problems
Yes No	Asthma	Yes No	Liver disease
Yes No	Blood transfusion	Yes No	Low blood pressure
Yes No	Cancer/ Chemotherapy	Yes No	Lupus
Yes No	Colitis	Yes No	Mitral Valve Prolapse
Yes No	Congenital Heart Defect	Yes No	Pacemaker
Yes No	Diabetes	Yes No	Psychiatric problems
Yes No	Difficulty breathing	Yes No	Radiation treatment
Yes No	Emphysema	Yes No	Rheumatic / Scarlet fever
Yes No	Epilepsy	Yes No	Seizures
Yes No	Fainting spells	Yes No	Shingles
Yes No	Frequent headaches	Yes No	Sickle cell disease
Yes No	Glaucoma	Yes No	Sinus problems
Yes No	Hay fever	Yes No	Stroke
Yes No	Heart Attack	Yes No	Thyroid problems
Yes No	Heart Murmur	Yes No	Tuberculosis
Yes No	Heart Surgery	Yes No	Ulcers
Yes No	Hemophilia	Yes No	Venereal Disease
Yes No	Hepatitis	Yes No	

Please list any medical condition(s) that you have ever had

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes No	Aspirin	Yes No	Latex
Yes No	Codeine	Yes No	Penicillin
Yes No	Dental Anesthetics	Yes No	Tetracycline
Yes No	Erythromycin	Yes No	Other
Yes No	Jewelry / Metals		

Please list any other drugs/materials that you are allergic to

6. DENTAL HISTORY

Why have you come to the dentist today? _____

 Date of last dental visit _____
 Has your doctor or dentist ever told you that you require
 antibiotics before dental treatment? Yes No
 Are you currently in pain? Yes No
 Have you ever had a serious / difficult problem associated
 with any previous dental work? Yes No
 Do you or have you ever experienced pain / discomfort in you
 jaw joint (TMJ/TMD)? Yes No
 Your current dental health is Good Fair Poor
 Do you like your smile? Yes No
 Do your gums ever bleed? Yes No
 How many times a week do you floss? _____
 How many times a day do you brush? _____
 Type of toothbrush bristles Hard Medium Soft

7. DISCLAIMER

I understand that the information I have given today is correct
 to the best of my knowledge. I also understand that this
 information will be held in the strictest of confidence and it is
 my responsibility to inform this office of any changes in my
 medical status. I authorize the dental team to perform any
 necessary dental services that I may need during diagnosis
 and treatment with my informed consent.

In the event that payment in full or for charges incurred is not
 made, I agree to pay all costs of collection including a 50%
 collection fee, attorney fees and court costs.

Signature _____

Date _____

**PAYMENT IS DUE IN FULL AT TIME OF
 TREATMENT UNLESS PRIOR
 ARRANGEMENTS HAVE BEEN APPROVED.**

**Our office is HIPAA compliant and committed to
 meeting or exceeding the standards of infection
 control mandated by OSHA, the CDC, and the ADA.**

DC
 DENTAL CARE OF FREMONT

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

Doctor's comments _____

MEDICAL HISTORY UPDATE

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

